COMMONWEALTH of VIRGINIA
Department of Health
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State Health Commissioner
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May 15, 2024

MEMORANDUM

TO: The Honorable L. Louise Lucas
Chair, Senate Finance and Appropriations Committee

The Honorable Ghazala F. Hashmi
Chair, Senate Education and Health Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Vivian E. Watts
Chair, House Finance Committee

The Honorable Mark D. Sickles
Chair, House Health and Human Services Committee

FROM: Karen Shelton, MD
State Health Commissioner, Virginia Department of Health

SUBJECT: Administration of Cancer Drugs in an In-Physician Office Setting

This report is submitted in compliance with the Virginia Acts of the Assembly – Chapter 582 of the 2023 Session, which states:

> *The Secretary of Health and Human Resources, in collaboration with the Department of Health, to convene a workgroup to analyze and review current reimbursement and operational challenges for medical practices that administer anti-cancer drugs in an in-office setting to patients whose costs for such treatment are paid for by Medicaid, Medicare or TRICARE (Appendix A). The workgroup is required to submit a report of its findings and recommendations to the Chairmen of the House Committee on Finance, the House Committee on Appropriations, the House Committee on Health, Welfare and Institutions, the Senate Committee on Finance and Appropriations, and the Senate Committee on Education and Health by November 15, 2023.*

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

KS/AJ
Enclosure

Pc: The Honorable John Littel, Secretary of Health and Human Resources

REPORT OF THE CHAPTER 582 STAKEHOLDER WORKGROUP

REPORT TO THE GENERAL ASSEMBLY

2023

OFFICE OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES

PREFACE

Chapter 582 (HB2200) of the 2023 Session directed the Secretary of Health and Human Resources, in collaboration with the Department of Health, to convene a workgroup to analyze and review current reimbursement and operational challenges for medical practices that administer anti-cancer drugs in an in-office setting to patients whose costs for such treatment are paid for by Medicaid, Medicare or TRICARE (Appendix A). The workgroup is required to submit a report of its findings and recommendations to the Chairmen of the House Committee on Finance, the House Committee on Appropriations, the House Committee on Health, Welfare and Institutions, the Senate Committee on Finance and Appropriations, and the Senate Committee on Education and Health by November 15, 2023. This report was prepared by the Department of Health on behalf of the Secretary of Health and Human Resources.

WORKGROUP MEMBERS

Office of the Secretary of Health and Human Resources
James Williams, Deputy Secretary
Virginia Association of Hematologists and Oncologists
Dr. Richard Ingram, President, Virginia Association of Hematologists and Oncologists; Practicing Hematologist/Oncologist, Shenandoah Oncology
Kathy Smith, State Controller, Virginia Oncology Associates
Allison Rollins, Senior Manager, Government Relations, The U.S. Oncology Network
Joel Andrus, Kemper Consulting, Inc.
Virginia Department of Medical Assistance Services
Dr. John Morgan, Chief Clinical Information Officer
Maryann McNeil, Pharmacy Manager
Tiaa Lewis, Director of Program Operations
Virginia Health Information, Inc.
Kyle Russell, Chief Executive Officer
Virginia Association of Counties
Katie Boyle, Director of Government Affairs
Virginia Municipal League
Joe Flores, Director of Fiscal Policy
Medical Society of Virginia
Kelsey Wilkinson, Senior Government Affairs Manager
Virginia Department of Health
Joseph Hilbert, Deputy Commissioner for Governmental and Regulatory Affairs
Sandra Serna, Director, Office of Health Equity
Victoria Zwicker, Comprehensive Cancer Control Coordinator, Office of Family Health Services

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EXECUTIVE SUMMARY

Chapter 582 (HB2200) of the 2023 Session directed the Secretary of Health and Human Resources, in collaboration with the Department of Health, to convene a workgroup to analyze and review current reimbursement and operational challenges for medical practices that administer anti-cancer drugs in an in-office setting to patients whose costs for such treatment are paid for by Medicaid, Medicare or TRICARE. The workgroup is required to submit a report of its findings and recommendations to the Chairmen of the House Committee on Finance, the House Committee on Appropriations, the House Committee on Health, Welfare and Institutions, the Senate Committee on Finance and Appropriations, and the Senate Committee on Education and Health by November 15, 2023. This report was prepared by the Department of Health on behalf of the Secretary of Health and Human Resources. Findings and recommendations are listed below.

FINDINGS AND RECOMMENDATIONS

1. Preliminary analysis performed by Virginia Health Information concerning cost and reimbursement of office-administered cancer drugs indicated wide variation in reimbursement rates within established fee schedules. Virginia Health Information should perform further analysis in order to address comments and questions raised by members of the workgroup.

2. There are numerous billing codes used by Medicare for which there is no corresponding reimbursement established by Medicaid. The Department of Medical Assistance Services should continue discussions with the U.S. Oncology Network concerning its coverage and reimbursement of office-administered cancer drugs.

3. The U.S. Oncology Network and Virginia Oncology Associates identified concerns regarding continuity of care following changes during the open enrollment period, and concerns with patient transportation, for Medicaid enrollees receiving treatment at community-based oncology practices. The Department of Medical Assistance Services should continue discussions with these stakeholders to address stated concerns.

INTRODUCTION

WORKGROUP MANDATE

Chapter 582 of the 2023 Session directed the Secretary of Health and Human Resources, in collaboration with the Department of Health, to convene a workgroup to analyze and review current reimbursement and operational challenges for medical practices that administer anti-cancer drugs in an in-office setting to patients whose costs for such treatment are paid for by Medicaid, Medicare or TRICARE (Appendix A). The workgroup is required to submit a report of its findings and recommendations to the Chairmen of the House Committee on Finance, the House Committee on Appropriations, the House Committee on Health, Welfare and Institutions, the Senate Committee on Finance and Appropriations, and the Senate Committee on Education and Health by November 15, 2023.

WORKGROUP ACTIVITIES

The workgroup met on October 12, 2023. The meeting was held in-person at the Virginia Department of Health central office, although a few workgroup members participated virtually. The workgroup received a presentation from Virginia Health Information, Inc. (VHI) summarizing the results of a preliminary cost analysis of office-administered cancer drugs in Virginia. The workgroup discussed the information contained in that analysis, and also had a broader discussion of operational challenges faced by medical practices that administer anti-cancer drugs in an in-office setting to patients whose costs for such treatment are paid for by Medicaid, Medicare or TRICARE. The meeting minutes are attached as Appendix C. Subsequent to the meeting the Virginia Association of Hematologists and Oncologists, and the Department of Medical Assistance Services provided VDH staff with supplemental material for inclusion in the report.

REPORT OUTLINE

This report presents the results of VHI's Preliminary Cost Analysis of Office Administered Cancer Drugs in Virginia. The report also summarizes the workgroup's discussion of reimbursement and operational challenges for medical practices that administer anti-cancer drugs in an in-office setting to patients whose costs for such treatment are paid for by Medicaid, Medicare or TRICARE. Finally, the report contains several findings and recommendations.

PRELIMINARY COST AND REIMBURSEMENT ANALYSIS OF OFFICE-ADMINISTERED CANCER DRUGS IN VIRGINIA

Virginia Health Information (VHI) reported the results of its preliminary analysis to the workgroup. The analysis provided the workgroup with information concerning total reimbursement for office-administered drugs statewide, average reimbursement per encounter, and average per encounter spend changes.

<table>
<tr><th colspan="3">Reimbursement of Office Administered Cancer Drugs in Virginia</th></tr>
<tr><td>Total Statewide</td><td>Average Per Encounter (2021)</td><td>Per Encounter Spend Changes (2019-2012)</td></tr>
<tr><td>Medicare - $300-$350 million</td><td>Medicare - $890</td><td>Medicare: 1.7% ($861-$890)</td></tr>
<tr><td>Medicaid - $60-70 million</td><td>Medicaid - $682</td><td>Medicaid: 2.5% ($650-$682)</td></tr>
<tr><td>Commercial - @$160-$180 million</td><td rowspan="2">Commercial - $1,019
Patient Responsibility
• Medicare Advantage: 6.5%
• Medicare FFS: 20%
• Medicaid: 1-2%
• Commercial: 3%</td><td>Commercial: 2.6% ($968-$1019)</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="3">Rate Variation - for range of J9000-J9999 within fee schedule files
• Medicaid (2023): Average - $715, range of $.07 to $43,378
• TRICARE (2023): Average - $674, range of $2.68 - $23,577, slight decrease between years</td></tr>
<tr><td colspan="3">Source: VHI Preliminary Analysis of data contained in Virginia All Payer Claims Database, TRICARE Fee Schedule, CMS Physician Payment Database, and DMAS Fee Schedule.</td></tr>
</table>

Table1: Reimbursement of Office-Administered Cancer Drugs in Virginia

VDH described the following with respect to its methodology:

- Healthcare Common Procedure Coding System range J9000-J9999 ("J Codes") were used to define physician office-administered chemotherapy drugs; theses codes are used for billing;
- Milliman HCG-Detail "Office Administered Drugs-Chemotherapy" was used to define encounters with All Payer Claims Database;
- "Reimbursement" defined as total insurance payment plus patient responsibility; and
- Fee schedules per individual code, APCD data per "encounter" includes J Code plus associated office fees.

In presenting the results, VHI noted several limitations to the preliminary analysis:

- No specific adjustments for drug or cancer reimbursement drugs were taken into account
- VHI did not have any utilization data for TRICARE
- There are some differences in applicable time frames between the various data sources
- Scope is only office-administered drugs, not prescription claims or rates
- Only payment data was used for Medicare, not the full fee schedule
- Optima/Virginia Premier was removed for Medicaid cost trends

Workgroup members raised a number of questions with respect to the analysis. Ms. Rollins asked if Virginia Health Information (VHI) could determine which J-codes tend to vary significantly over time between Medicaid and Medicare. Mr. Flores asked if there is a way to further analyze the anomalies between the different fee schedules, since there is such a large range. Mr. Russell stated that VHI could perform additional analysis if it is given sufficient time.

Mr. Flores noted that the challenge is cost of services or medication for the provider in comparison to reimbursement. Mr. Flores asked if there is a way to determine which J-codes are driving the high cost. Dr. John Morgan said that Department of Medical Assistance Services could review how the reimbursement rates for J-codes for fee-for-service (FFS) Medicaid members are set and provide follow-up information. Ms. Rollins, however, emphasized that some of the high-cost drugs are not the ones providers are typically prescribing. Ms. Rollins noted that she didn't want to exclude something in the analysis that may be most impactful for small practices.

REIMBURSEMENT CHALLENGES

As a follow up to the Workgroup Meeting, the U.S. Oncology Network cross-referenced Quarter 4 of the 2023 Medicare Physician Fee Schedule; the Medicare Clinical Laboratory Fee Schedule; and DMAS 2023 Quarter 4 Fee Schedules against Virginia community oncology practices' 2023 utilization data. According to the U.S. Oncology Network, there are several J Codes that either do not have a reimbursement rate set by the most recent fee schedule (four codes in all), and several J Codes and CPT codes for services outpatient oncologists may attempt to bill for, which are classified as Individual Consideration ("IC"), meaning there is no set reimbursement for these services (44 codes in all). These billing codes are listed in Appendix C.

The U.S. Oncology Network stated that it wants to continue to explore opportunities to create consistent reimbursement around these services and contends that many of these codes are for standard care required to treat cancer patients. Kathy Smith of Virginia Oncology Associates emphasized that in addition to the cost of the drugs, other operating expenses (i.e., providing

clean rooms, facility costs, and use of robotics in the mixing of chemotherapy drugs to protect employees) are critical to provide quality care but are not reimbursed. Virginia Oncology Associates requested consideration of reimbursement for additional types of operating costs.

U.S. ONCOLOGY NETWORK REVIEW OF BILLING CODES

The U.S. Oncology Network reported that there are four J Codes used by Medicare (also known as MCR Codes) that do not have reimbursement rates set on the most current DMAS FFS fee schedule; however, all have been on the market for at least 2 years.

- Anifrolumab-fnia (J0491) is primarily indicated to treat lupus; however, in cancer care, it's a supportive drug necessary for patients with lupus-like side effects to their anti-cancer treatment.
- Tisotumab vedotin-tftv (J9273) treats cervical cancer,
- Loncastuximab tesirine-lpl (J9359) treats non-hodgkins lymphoma, and
- Pemetrexed (J9304), which is a combination therapy necessarily co-prescribed with other DMAS-covered platinum-based medications, is a first line treatment for certain metastatic lung cancers. It is very commonly prescribed and a critical drug for many patients in the fight against cancer.

There were 44 other ambulatory oncology care-relevant billing codes used by Medicare that were classified as "IC" or Individual Consideration, on the current DMAS FFS fee schedule, meaning there is no set reimbursement for these services. The practices supported by the U.S. Oncology Network typically see wide variations in reimbursement and utilization management policies for these codes across the various MCOs. According to the U.S. Oncology Network, elevating these codes from IC to an official DMAS rate for its FFS members could help improve the financial health of physician practices. Some of these codes represent professional services while others represent a wide variety of components of anti-cancer treatment protocols including prescription medications, clinical lab services, in-office procedures, imaging services, and radiation therapy services. Additional time would be needed for the U.S. Oncology Network to conduct an adequate projection of the impact that more predictable rate setting could have for groupings of MCR codes.

MEDICAID REIMBURSEMENT METHODOLOGY

According to DMAS, physician-administered drugs (PADs) submitted under the medical benefit are reimbursed at 106% of the average sales price (ASP) as published by the Centers for Medicare and Medicaid Services (CMS) for fee-for-service members. PADs without an ASP on the CMS reference file are reimbursed at the provider's actual acquisition cost. Covered entities using drugs purchased at the prices authorized under § 340B of the Public Health Service Act for Medicaid members shall bill Medicaid their actual acquisition cost. The CMS source files are contained at: https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price.

Compensation for administrative services associated with PAD administration in a non-hospital outpatient setting can be made via reimbursement of drug administration codes that may

be billed in conjunction with administered drugs. Which code may be appropriate to bill depends on what kind of drug is administered (i.e., administrative complexity, observation requirements), how the product was obtained (i.e., may be different if products fall under the Vaccines for Children program), and whether DMAS is authorized to reimburse corresponding billing codes. According to DMAS, providers may reference the DMAS FFS provider fee file for clarity on which codes are covered for FFS members.

DMAS stated that compensation for administrative services/efforts provided in conjunction with physician-administered drug (PAD) delivery in an outpatient hospital setting are included in Enhanced Ambulatory Patient Groups (EAPG) payments. An overview of the methodology is available here).

DMAS reported that providers are allowed to negotiate rates with the managed care organizations (MCOs). MCOs contract with DMAS to ensure access to contractually stipulated services, and by extension, a network of providers able to provide said services. MCOs are expected to enter into contractual agreements with these providers as outlined in Sections 7.1 (Provider Network), 7.3.6 (Provider Agreements) and Section 12.0 (Provider Payment) of the DMAS Cardinal Care Contract (viewable here). DMAS' managed care contract does not prohibit MCOs from negotiating rates with providers for services.

DMAS does not currently have state plan authority to directly reimburse for value-added services (i.e., Community Health Worker Services) performed for FFS members, however MCOs are not precluded from directly reimbursing for CHW services. While all of DMAS' current MCOs have endorsed employing or contracting with CHWs, DMAS is not aware of any that are enrolling third-party CHWs as providers for direct reimbursement currently. DMAS reported that it is aware of, and will monitor, any Medicare action related to reimbursement of CHWs, and will continue to assess how best to leverage managed care and state resources to address the behavioral, community and social factors that contribute to poor health.

OTHER OPERATIONAL CHALLENGES

The U.S. Oncology Network and Virginia Oncology Associates discussed additional operational challenges during the workgroup meeting. These include changes in patient coverage during Medicaid open enrollment periods, patient transportation to and from appointments, and being able to recruit and retain qualified staff for physician practices. DMAS and VDH discussed ongoing activities intended to help address these issues.

CHANGES IN PATIENT COVERAGE DURING OPEN ENROLLMENT

The workgroup was told there are situations where a patient previously received care authorization under a particular Medicaid MCO plan, but the patient switches plan during open enrollment, and the provider is not made aware, which complicates subsequent billing and reimbursement. That is because the newly selected plan may have different coverage provisions. According to oncologists, this type of situations raises concerning regarding continuity of patient care while trying to figure out the appropriate payment.

DMAS explained that, for physician-administered drug authorizations granted under the medical benefit (i.e., for reimbursement of J-codes), DMAS is available to connect with oncology providers to understand their experience navigating MCO recognition of previously granted authorizations and take necessary next steps to ensure good-faith plan adherence to contractual requirements and eliminate unnecessary operational barriers. The CRMS (Care Management Solution) module created by DMAS collects daily, among other data, medical and pharmacy service authorization information from the MCOs. When a member switches MCOs, all current and historic service authorizations are sent to the new MCO. The new MCO must honor the former MCOs current authorizations for up to 30 days. Additionally, historical authorizations are shared by DMAS with the MCOs to ensure that duplicative care is prevented. For concerns regarding authorization reciprocity for drugs dispensed via the pharmacy benefit, providers can send emails to pharmacyteam@dmas.virginia.gov with member name, Medicaid ID number, date of service, medication name and the MCOs involved. MCOs are required to provide at least 30 days continuity of previously authorized prescriptions.

PATIENT TRANSPORTATION

The Virginia Association of Hematologists and Oncologists, as well as the Medical Society of Virginia, discussed ongoing challenges faced by community oncology practices in transporting patients, particularly patients enrolled in the Medicaid program, to and from appointments. DMAS described its ongoing efforts to address difficulties with member non-emergent medical transportation (NEMT) to/from oncology and other specialty-type visits. NEMT is an important part of the healthcare continuum, especially for those with chronic conditions such as diabetes, heart disease, cancer, COPD, or asthma.

A Medicaid NEMT broker contracts with a health plan or State Medicaid Agency to manage patient transportation in a designated area. The current DMAS NEMT delivery model has four NEMT brokers that are contracted to manage the six statewide NEMT programs. This includes the FFS and five MCO NEMT programs. Several of the brokers manage more than one NEMT program.

DMAS is aware of the regional challenges associated with Member transportation and the provision of Non-Emergency Medical Transportation benefits to Medicaid eligible services. The DMAS Transportation Management Services Unit, collaborates regularly with the Managed Care Organizations, as well as the NEMT Transportation Brokers to develop strategies for identifying and appropriately addressing gaps within the NEMT transportation network. A significant part of this collaborative effort is the continuous trend analysis conducted with the NEMT Brokers which demonstrate which regions in Virginia need a focused effort in terms of network develop. DMAS then works with the NEMT Brokers to ensure that the network development activities are reflective of the gaps identified within the trend analysis in a manner that is impactful. DMAS experienced significant negative impact in relation to trip delivery caused by the COVID 19 Public Health Emergency. All FFS and MCO NEMT programs still have not recovered total trip counts that had taken place before the pandemic. In addition, 96 NEMT providers closed

permanently because of the loss of revenue during the pandemic. DMAS provided the following information concerning recent actions the FFS NEMT Broker has taken to improve network adequacy:

Southwest Virginia Network Development -Year to Date 2023

Total new Transportation Provider acquisitions – 8

· Vehicles added – 47

- Ambulatory – 30
- Wheelchair -13
- ALS/BLS – 2
- VS vehicles – 2

Network Development in Progress - October 2023- December 2023

Total remaining new provider acquisitions – 13

· Estimated vehicles – 71

- Ambulatory vehicles – 45
- Wheelchair vehicles – 18
- Van-Stretcher vehicles – 7
- BLS/ALS vehicles – 2

DMAS is working with the MCOs and their respective NEMT Brokers to ensure that similar endeavors are being undertaken to improve the overall adequacy of the NEMT networks.

STAFF RECRUITMENT AND RETENTION

The workgroup discussed a number of factors which make recruitment and retention of a qualified healthcare workforce challenging. The Virginia Association of Hematologists and Oncologists, Virginia Oncology Associates, and the U.S. Oncology Network said that strengthening the primary health care workforce will also help to strengthen oncology care as it will facilitate early diagnosis which will lead to improved patient outcomes.

The Virginia Department of Health administers numerous health care workforce incentive programs – significantly focused on primary care. Virginia offers a range of scholarship opportunities to support nursing education and practice. These scholarships are available to those who wish to pursue certifications or licensures as Certified Nurse Assistants, Licensed Practical Nurses, Registered Nurses, Nurse Practitioners, Nurse Midwives, Nurse Educators, and those serving as Nurse Preceptors. In exchange for the scholarship, graduates must commit to serving as a nurse in Virginia.

Additionally, Virginia offers a handful of incentive programs to physicians. However, only one program – the Conrad 30 Waiver Program – is open to subspecialty providers like hematologists or oncologists. The Virginia Conrad 30 Waiver Program agrees to waive the "two-year home country physical presence requirement" by sponsoring International Medical Graduates on J-1 visas who agree to serve in designated shortage areas of the Commonwealth. Non-primary care physicians who fill a "documented community health care need" may also be considered for J-1 visa waivers with appropriate documentation. Full details about this program and the eligibility requirements can be found on the Virginia Department of Health website at https://www.vdh.virginia.gov/health-equity/conrad-30-waiver-program-overview/.

FINDINGS AND RECOMMENDATIONS

1. Preliminary analysis performed by Virginia Health Information concerning cost and reimbursement of office-administered cancer drugs indicated wide variation in reimbursement rates within established fee schedules. Virginia Health Information should perform further analysis in order to address comments and questions raised by members of the workgroup.

2. There are numerous billing codes used by Medicare for which there is no corresponding reimbursement established by Medicaid. The Department of Medical Assistance Services should continue discussions with the U.S. Oncology Network concerning its coverage and reimbursement of office-administered cancer drugs.

3. The U.S. Oncology Network and Virginia Oncology Associates identified concerns regarding continuity of care following changes during the open enrollment period, and concerns with patient transportation, for Medicaid enrollees receiving treatment at community-based oncology practices. The Department of Medical Assistance Services should continue discussions with these stakeholders to address stated concerns.

APPENDIX A – CHAPTER 582 OF THE 2023 ACTS OF ASSEMBLY.

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Secretary of Health and Human Resources (the Secretary), in collaboration with the Department of Health, shall convene a work group to analyze and review current reimbursement and operational challenges for medical practices that administer anti-cancer drugs in an in-office setting to patients whose costs for such treatment are paid for by Medicare, Medicaid, or TRICARE. The analysis shall consider the impact on and accessibility of such treatment for Medicaid, Medicare, and TRICARE patients. The work group shall include relevant stakeholders, including representatives from the Medical Society of Virginia, the Virginia Association of Hematologists and Oncologists, the Virginia Association of Counties, and the Virginia Municipal League. Assistance shall be provided to the work group by the Department of Medical Assistance Services. The work group shall complete its meetings by October 1, 2023, and submit a report of its findings and recommendations to the Chairmen of the House Committee on Finance, the House Committee on Appropriations, the House Committee on Health, Welfare and Institutions, the Senate Committee on Finance and Appropriations, and the Senate Committee on Education and Health by November 15, 2023.*

APPENDIX B – ACRONYMS AND ABBREVIATIONS

This is a listing of the acronyms and abbreviations appearing throughout the report and its appendices.

VDH – Virginia Department of Health

FFS – Fee for Service

APPENDIX C – THE US ONCOLOGY NETWORK MCR CODE UTILIZATION IN VIRGINIA

MCR Codes Reimbursed by Medicare But Not By DMAS in Q4 of 2023	
MCR Code	**Description**
J0491	INJECTION, ANIFROLUMAB-FNIA (SAPHNELO), 1 MG
J9273	INJECTION, TISOTUMAB VEDOTIN-TFTV (TIVDAK), 1 MG
J9304	INJECTION, PEMETREXED (PEMFEXY), 10 MG
J9359	INJECTION, LONCASTUXIMAB TESIRINE-LPYL (ZYNLONTA),
MCR Codes Reimbursed by Medicare; But Only Covered at IC By DMAS in Q4 of 2023	
MCR Code	**Description**
Q2054	LISOCABTAGENE MARALEUCEL, UP TO 110 MILLION AUTOLO
J1302	INJECTION, SUTIMLIMAB-JOME (ENJAYMO), 10MG
J1456	INJECTION, FOSAPREPITANT (TEVA)
J9063	INJ MIRVETUXIMAB SORAVTANSINE-GYNX (ELAHERE) 1 MG
J9196	INJ GEMCITABINE HCL (ACCORD)
J9347	INJ, TREMELIMUMAB-ACTL, (IMJUDO) 1 MG
25078	RESECT FOREARM/WRIST TUM=3CM
28047	RESECT FOOT/TOE TUM > 3CM
32998	PERQ RF ABLATE TX PUL TUMOR
36591	BLOOD DRAW/VENOUS ACCESS PORT
38208	THAWING FROZEN PRODUCT
81246	FLT3 GENE ANALYSIS
81272	KIT GENE TARGETED SEQ ANALYS
83521	IG LIGHT CHAINS FREE EACH
84165	Assay Of Serum Proteins
90471	Immunization Admin
90472	Immunization Admin, Each Add
90875	PSYCHOPHYSIOLOGICAL THERAPY
96377	TX/PRO/DX INJ NEW DRUG ADD ON
99358	Prolonged Serv, W/O Contact
99359	Prolonged Serv, W/O Contact
99402	Preventive Counseling, Indiv
99403	Preventive Counseling, Indiv
99404	Preventive Counseling, Indiv
99418	PROLNG IP/OBS E/M EA 15 MIN
99448	INTER TELE/INT ASSESS MGMT21-30 MINS MED CONSULT
99491	CHRNC CARE MGMT SVC 30 MIN
99497	ADVNCD CARE PLAN 30 MIN
99498	ADVNCD CARE PLAN ADDL 30 MIN
G0403	ELECTROCARDIOGRAM, ROUTINE ECG WITH 12 LEADS; PERF
G0413	PELVIC RING FRACTURE UNI/BIL
G2212	PROLONG OUTPT/OFFICE VIS
G6001	ULTRASONIC GUIDANCE FOR PLACEMENT OF RADIATION THE
G6003	RAD TRX DEL, SNGL TRX AREA, SNGL PORT OR PARALLEL O

G6004	RAD TRX DEL, SINGLE TRX AREA, SINGLE PORT OR PAR OP
G6005	RAD TRX DEL, SINGLE TRX AREA, SNGL PORT OR PARALLEL
G6007	RAD TRX DEL,2 SEP TRX AREAS,3 OR MORE PORTS ON A S
G6009	RAD TRX DEL,2 SEP TRX AREAS,3 OR MORE PORTS ON A S
G6011	RADIATION TRX DEL,3 OR > SEP TRX AREAS, CUSM BLOCK
G6012	RAD TRX DEL,3 OR MORE SEP TRX AREAS, CUSTM BLOCK, TA
G6013	RAD TRX DEL,3 OR MRE SEP TRX ARS, CSTM BLOCK, TANGT
G6014	RAD TRX DEL,3 OR MORE SEP TREAT AREAS, CSTM BLCK,
G6015	INTENSITY MOD TRX DEL, SNGL/MLTPL FLDS/ARCS, VIA NA
G6016	COMPENSATOR-BASED BEAM MOD TRX DEL OF INVRS PLND T

APPENDIX D – MINUTES OF WORKGROUP MEETING – DRAFT NOT APPROVED

HB2200 Stakeholder Workgroup Meeting Minutes
October 12th, 2023 – 10:30 AM
Webex & 5th Floor Conference Room, James Madison Building

Attendees: Dr. Richard Ingram (Virginia Association of Hematologists and Oncologists), Kelsey Wilkinson (MSV), Kathy Smith (Virginia Oncology Associates), Joel Andrus (Kemper Consulting), Allison Rollins (US Oncology), Kyle Russell (VHI), Joe Flores (VML), Sandra Serna (VDH), Joseph Hilbert (VDH), Vicki Zwicker (VDH), Katie Boyle (Virginia Association of Counties), Dr. John Morgan (DMAS), Maryann McNeil (DMAS), Tiaa Lewis (DMAS), John Ringer (VDH), Rebecca Brookman (VDH), Emily Lafon (VHHA), Dawniece Trumbo (VHI)

Welcome & Introductions

Mr. Hilbert called the meeting to order at 10:32 am. He provided background and led introductions.

Preliminary Cost Analysis of Office Administered Cancer Drugs in Virginia

Kyle Russell presented the results of the preliminary Cost Analysis of Office Administered Cancer Drugs in Virginia. He concluded that reimbursement could vary significantly depending on who the payor is and that the reimbursement rate variation for J9000-J9999 codes is immense.

Allison Rollins asked if the fee-for-service and managed care plans were separated out for Medicaid or if they were combined in this analysis. Mr. Russel stated that they were averaged out for Medicaid overall.

Dr. Richard Ingram stated that, from the provider perspective. there is an emergent cost shifting to the patient overtime, especially with the rising cost of oncological drugs. The one to two percent of cost that is the patient's responsibility can be detrimental. Mr. Russell agreed and noted that the percent of the cost that is the patient's responsibility is a large number state-wide.

Ms. Rollins asked if Virginia Health Information (VHI) could determine which J-codes tend to vary significantly over time between Medicaid and Medicare. Mr. Russell stated that VHI could analyze that given sufficient time.

Joe Flores noted that the challenge is cost of services or medication for the provider in comparison to reimbursement. Mr. Flores asked if there is a way to determine which J-codes are driving the high cost. Dr. John Morgan mentioned that Department of Medical Assistance Services (DMAS) could review exactly how the reimbursement rates for J-codes are set and follow-up. Ms. Rollins, however, emphasized that some of the high-cost drugs are not the ones providers are typically prescribing. Ms. Rollins noted that she didn't want to exclude something in the analysis that may be most impactful for small practices.

Mr. Flores asked if there is a way to tease out the anomalies between the different fee schedules, since there is such a large range. Mr. Russell stated that VHI would have to review claims to then determine what is driving the fee schedule; however, they can't do that for TRICARE.

Kathy Smith emphasized that the cost of the drugs is only a piece of this puzzle – operating expenses (i.e., providing clean rooms, facility costs, use of robotics in the mixing of chemotherapy drugs to protect employees) are critical to provide quality care but are not reimbursed. In addition, oncological facilities are providing this care regardless of the patient's ability to pay.

Mr. Hilbert asked who the regulatory agency is that oversees oncology centers. Ms. Rollins stated that it is DMAS, Board of Pharmacy, and Board of Medicine.

Joel Andrus stated that challenges with managing this population have increased over the years. The benefit of oncology centers is that patients can get their care in one location at an independent, physician-owned practice. Doctors have no idea if the patient can pay or who their payor is and the goal is that they would never know, but paying for the payor patients is becoming increasingly more expensive and difficult.

Mr. Andrus mentioned that one possibility to cut costs is to look for the Business, Professional, and Occupational Licensing tax (BPOL) exemptions for infused medications, since paying this tax on top of the other expenses becomes even more burdensome. Mr. Andrus highlighted that the main goal is to determine how oncology facilities can continue provide the resources necessary to their patients, so patients are not limited in their care options.

Mr. Flores stated that it is informative that the General Assembly decided to remove any reference to taxation from the final approved version of HB2200. He noted that the General Assembly could have directed the Secretary of Finance to convene the workgroup, but instead chose to direct the Secretary of Health and Human Resources to convene the workgroup.

Mr. Andrus mentioned that, outside of reimbursement, patient transportation is always an issue and not just for oncology. Kelsey Wilkinson agreed and stated that certain areas in Virginia rely very heavily on public transportation.

Tiaa Lewis stated that, coming out of the pandemic, it has been difficult for DMAS's transportation vendors to onboard drivers; however, DMAS is steadily making progress with changes and improvements regarding transportation plans.

Mr. Andrus asked if there is anything the Workgroup can put together to help DMAS improve. Ms. Lewis stated that DMAS would like to hear feedback on the use of non-traditional transports (i.e., Lyft and Uber). Ms. Lewis also said that DMAS has been able to get a good idea of where the problem areas are in Virginia.

Dr. Ingram noted that a hospital-based system would be more expensive for the payor (in-patient versus out-patient) and it would create fragmented care for the patient.

Discussion of Selected Topics

Mr. Hilbert asked Mr. Andrus if there were other topics that he wanted to discuss in addition to what had already been covered.

Mr. Andrus highlighted the following additional topics:

- Changes in patient coverage during open enrollment (authorization under one plan but patient switches plan and is then billed under the new plan)
    - Providers have to do a lot to get reimbursed.
    - Concerns regarding continuity of care while figuring out the payment – moving patients into a different setting during this time defeats the purpose of oncology centers.
- Consideration of reimbursement for operating costs that increase quality of care, which are not currently reimbursable.
- Workforce issues – All medical services have challenges with staffing now. How do organizations attract and retain good nurses?

Changes in Patient Coverage During Open Enrollment

Ms. Lewis stated that it is extremely important for providers to use the tools that DMAS has available and suggested checking patients' eligibility monthly. She also mentioned that there are mechanisms in place to ensure that there isn't a disruption of care; however, it seems there still is a disruption. Dr. Morgan confirmed that providers can get authorization from members' new plan but sought affirmation that providers felt it was only after an unreasonable amount of effort has been put into sharing information. Dr. Morgan mentioned that reaching out to DMAS and providing detail around specific instances will help DMAS identify specific issues.

Consideration of Reimbursement for Operating Costs

Dr. Morgan stated that DMAS is committed to ensuring that providers can be paid for the services provided. Again, Dr. Morgan and Ms. Lewis mentioned that they could analyze how the J-code reimbursement rates are calculated and follow-up with the Workgroup.

Dr. Morgan also noted that if there are non-J-Code costs that tend to be reimbursed by other payors but not by DMAS, then DMAS would be happy to review why they are or are not able to

reimburse those and provide an overview of what steps would need to be taken to allow for reimbursement.

Mr. Andrus asked if or how other states are reimbursing these costs. Dr. Morgan stated that DMAS often reviews how other states determine reimbursements for those codes and if they are including administrative costs.

Maryann McNeil asked if oncology is working with other commercial payors on value-based contracts. Ms. Smith stated that centers must provide certain services and perform at a certain level to participate in values-based contracts with commercial payors; for example, the Anthem Medical Homes program has very specific criteria oncology providers must meet. Dr. Ingram described the Enhancing Oncology Model (EOM) and Oncology Care Model (OCM) value-based programs from Medicare and said that these programs have affected the reimbursement of services by Medicare. Dr. Ingram noted that the EOM program has obligatory upside and downside risk for providers. Dr. Ingram also said that inflation and rising labor costs have never been reflected in Medicare reimbursements.

Workforce Issues

Workgroup members agreed that this issue is affecting all areas of healthcare and that bolstering primary care will in turn bolster specialty care. For this population, if patients can get into primary care for early diagnosis, then not only will cost of care be cheaper but patient outcomes will be significantly better as well.

Dr. Morgan stated that DMAS is willing and happy to help provide technical assistance. Sandra Serna also noted that the VDH Office of Health Equity, working closely with the Virginia Nursing Association, offers a vast number of nursing programs and she would be happy to share information regarding them.

Discussion of Next Steps

Mr. Hibert reviewed the main topics of discussion and reminded the Workgroup that a report needs to be prepared and submitted to the General Assembly by November 15th, 2023.

Based on the discussion, Workgroup members will send the information that they would like to see included in the report to Mr. Hilbert by October 20th, 2023. Mr. Hilbert will use those submissions to compile a draft report. The draft report will be shared with the workgroup members, prior to being sent to the Secretary of Health and Human Resources for further review and approval prior to submission to the General Assembly.

Meeting Adjourned: 12:03 PM